

Relapse Prevention

Introduction

The field of addictions continues to struggle with the revolving door of substance use disorder (SUD) treatment. According to the 2002 National Survey on Drug Use and Health, an estimated 3.5 million people aged 12 or older (1.5 percent of the population) received some kind of treatment for a problem related to the use of alcohol or illicit drugs in the 12 months prior to being interviewed. The view of addiction as a chronic relapsing disorder makes the prevention of relapse one of the critical treatment elements for both the clinician and the consumer.

Relapse prevention as a concept and as a treatment modality began in the 1970s as the realization that high relapse rates followed SUD treatment for alcohol, smoking, and heroin. Hunt (1971) found that more than half of abusers relapsed within three months and that a majority relapsed within six months following treatment. This led to the development and proliferation of cognitive-behavioral relapse prevention programs, the most renowned being Marlatt's relapse prevention model which became popular in the 1980s (Marlatt, 1984).

This model provides the conceptual framework for a majority of the research in relapse prevention. A major part of this relapse model relies on identifying situations likely to place an individual at risk of relapse, and the development of skills to avoid that situation or to deal with behaviors other than substance use. Key components of the model are anticipating and identifying high-risk situations, skills development to deal with those situations, and expecting positive outcomes from use of relapse prevention skills. Current research in the addiction field generally treats relapse as an outcome indicator, rather than focusing on the issue of relapse itself. The following sections present information on the ongoing research in this area.

Predictors of Relapse:

McKay (1999) reviewed studies examining predictors of relapse in substance users and critically reviewed their methodologies and findings. He concluded that retrospective reports can provide accounts of circumstances and experiences leading up to relapse, but are more likely to be inaccurate because of memory limitations. Prospective studies, while less likely to be affected by these limitations, may not capture factors that immediately precede relapse. The use of near real-time technology makes it possible to study the entire relapse process in much greater detail, but does not entirely eliminate retrospective bias. He then summarized the convergent findings from all the studies on relapse factors and found that negative emotional states, increased craving, reduced commitment to abstinence, lower self-efficacy, the urge to give up following a lapse, interpersonal problems and lack of coping efforts during periods of temptation were consistently found to predict relapse, regardless of which study methodology was employed.

Walton, Blow, and Booth (2000) compared SUD patients' and their counselors' perceptions of relapse risk during treatment and evaluated whether the perceptions predicted actual relapse after two years. Relapse risk was assessed using the Relapse Risk Index (RRI), an instrument that assesses confidence in abilities and need for services across four domains: coping skills, social support, resources, and leisure activities. Relapse was operationalized as alcohol and/or drug use two years following SUD treatment, and was assessed using a follow-up interview. Participants reported significantly greater confidence and greater need for services in the four domains than did their counselors. Participants' risk rating was additionally determined by the presence of polysubstance use, whereas the counselors' risk rating was influenced by income level – those participants with lower income were perceived as being at higher risk for relapse. One determinant of the higher risk ratings for both participants and counselors included higher problem severity.

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Alcohol relapse was predicted by the participants' ratings of coping skills and leisure activities and the counselors' ratings of coping skills. The counselors' ability to predict alcohol relapse was not significant once background characteristics were considered. Income was the only background characteristic significantly predicting alcohol relapse. Drug relapse was predicted by the participants' rating of social support. Polysubstance use was the only background characteristic that predicted drug relapse. The counselors were not proficient at predicting relapse to other drugs. Interestingly, the participants' relapse risk perceptions predicted both alcohol and drug relapse, even controlling for background characteristics in the case of alcohol. The authors suggest these findings indicate a need for more patient-centered SUD treatment.

Allsop, Saunders & Phillips (2000) examined the process of relapse. Using a sample of male problem drinkers (N=60) they found the higher self-efficacy after treatment, predicted a better outcome at 6 month follow up and was associated with a reduced risk of relapse over the 12-month follow-up. They also found that cognitive functioning was a predictor of treatment outcome and time to lapse. Other determinants of relapse found in the literature include anxiety, depression and insomnia (Willinger et al., 2002, Brower et al. 2001, Driessen et al. 2001, Strowig 2000.). Brower et al. (2001) found that insomnia was a predictor of relapse even when controlling for alcohol dependence and depression. However, a history of self-medicating with alcohol did not predict relapse. They suggest that routine questions about sleep could easily identify patients at risk of relapse.

Gossop et al. (2002) investigated the relationship between various types of coping responses and relapse to heroin use following residential treatment. Coping responses were assessed using items from the Processes of Change questionnaire. They found that clients that did not relapse used more cognitive, avoidance and distraction coping strategies at follow-up than at intake.

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Additionally, treatment completion was related to better outcome – those clients who remained abstinent after leaving treatment were about twice as likely to have completed their program. According to the authors, these findings suggest the need to develop and strengthen relapse prevention and relapse coping skills among drug misusers.

Walton et al. (2003) identified the individual and social/environmental predictors of relapse. With regard to the interpersonal or individual predictors, they found

that poorer self-efficacy predicted alcohol use directly. For clients, having lower income, being female, greater problem severity and being unmarried were associated with low self-efficacy. They conclude that these patients may benefit most by interventions designed to improve self-efficacy. Drug use was directly predicted by greater resource needs. The authors conclude that this finding indicates that treatment programs may benefit from incorporating advocacy therapies that train participants in obtaining needed resources – especially for clients who are female, minorities, unmarried or with lower incomes. Involvement in substance-using leisure activities was the only social/environmental factor that predicted both alcohol and drug use, supporting the notion that aftercare approaches for SUDs should assist people in establishing leisure activities that are free from alcohol and/or other drugs.

In an exhaustive review of the research literature on the relationship between stress and drug use and relapse, Sinha (2001) summarizes animal research and preclinical human research and concludes that stress, in addition to the drug itself, plays a key role in perpetuating drug use and relapse, but concludes that the mechanisms underlying the association in humans remains unclear and is an area for future research. A recent laboratory experiment using rats found that the neurochemical systems mediating stress-induced relapse are different from those mediating relapse induced by drugs and drug-related cues. They conclude that no single pharmacological or behavioral approach to treatment of addiction is likely to be sufficient (Stewart, 2003).

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Population Characteristics:

Walton, Blow and Booth (2003) published an additional study examining the relapse prevention needs of women and African Americans. Using the same relapse risk instrument, women reported significantly greater coping skills than men, fewer negative social influences to use substances, and less exposure to substances, even controlling for socioeconomic and treatment factors. African-Americans reported significantly greater coping, self-efficacy, and greater resource needs than Caucasians, controlling for the same background characteristics. African-American men reported the greatest exposure to substances, and African-American women reported a greater need for resources than Caucasians. The authors propose that diversity is needed in relapse prevention programs. For example, men may benefit more from relapse prevention services that address ways to cope with negative social influences or peer pressure to use alcohol or drugs in social

situations. African Americans may need relapse prevention approaches that provide more advocacy and teach skills to access community resources more efficiently.

Schutte et al. (2003) studied the predictors of relapse of older adults who were problem drinkers earlier in life. Although relapse was a relatively uncommon (11%) outcome in this particular study, a less severe drinking history, heavier baseline alcohol consumption, and lower baseline income were associated with relapse. They conclude that both current drinking behavior and drinking history are important to consider when making recommendations regarding older adults' alcohol consumption.

Pharmacological Treatments:

Currently, there is a new interest in medications, known as antidipsotropics, to prevent alcohol relapse. One of the most recent to be approved by the FDA was Naltrexone in 1994. Literature reviews and meta-analyses report that some of the existing pharmacological treatments for alcohol use, including a deterrent Disulfiram, and serotonergic antagonists, such as the SSRIs

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Fluoxetine and Citalpram, have not shown consistently efficacious results. Some newer medications, specifically Naltrexone and Acamprosate are proving to be efficacious in reducing alcohol consumption in alcoholics. Both appear to provide a comparable but modest effect on the likelihood of a patient's maintenance of abstinence. (Kranzler 2000, Kranzler and Van Kirk 2001).

Even though Naltrexone has had FDA approval for almost a decade, it is still not a widely used treatment. Thomas et al. (2003) conducted a study to examine the adoption of Naltrexone in alcohol treatment by clinicians and physicians using a conceptual model of technology diffusion. They found that Naltrexone was prescribed by only 15% of physicians for alcoholism, and that a majority of non-physician clinicians have never recommended Naltrexone for any clients. According to both types of clinicians, the decision to prescribe or not is influenced mostly by lack of information and the cost of the medications. The next most important barrier to the adoption of Naltrexone was the lack of sufficient evidence regarding its effectiveness. The authors conclude that for a new SUD medication to be adopted widely, information about it must be widely directed, clinicians must be convinced of its effectiveness, it must be adequately financed, and the treatment organizations in which clinicians work must promote its use.

Van Den Brink and Van Ree (2003) reviewed the existing pharmacological options for the treatment of heroin and cocaine-dependent patients. They conclude that both heroin and cocaine addiction can be conceptualized and treated as a chronic, relapsing disorder. The interventions directed at relapse prevention for heroin addiction, namely Naltrexone, are still problematic and only effective in a minority of motivated patients in stable living conditions with adequate social support. As of now, there are no proven effective pharmacological interventions available for the treatment of cocaine-dependent patients. Some new developments currently being researched include the potential role of cannabinoid receptor antagonists in opioid and cocaine relapse prevention, and the possibility that pharmacological attenuation of the stress response in opioid - and cocaine-dependent patients could reduce relapse.

Treatment Issues:

Gerwe (2000) studied the effectiveness of the High-Risk Identification and Prediction Treatment model (HRIPTM). This model was developed to investigate physiological and psychological conditions associated with the concept of negative emotional state, and to examine the origin and evolution of this condition in relation to addiction relapse. An in-depth case study was conducted to determine whether information that arises from the HRIPTM increases the patient's and the clinician's ability to address addiction relapse more effectively. Findings indicate that of those participants completing the HRIPTM program (n=30), 98% agreed that this ability had been gained.

Havermans and Jansen (2003) propose ways of increasing the efficacy of cue exposure treatment in preventing relapse of addictive behavior. Cue Exposure with Response Prevention (CERP) is a type of treatment in which a drug user is exposed repeatedly to stimuli associated with their addictive behavior. The authors present an argument using contemporary learning theory to support the proposition that extinction alone does not eliminate conditioned responding. They suggest that this type of treatment could benefit from modified CERP – specifically with the incorporation of retrieval cues into the exposure to stimuli, in order to reduce the probability of spontaneous recovery. In this case, a retrieval cue could serve as a reminder that is incorporated into the relapse prevention program.

Conclusion

Relapse appears to remain the norm rather than the exception in SUD treatment. Although widely researched for an extensive period of time, little is actually known and documented about the exact causes of relapse. Even less is known about the effect of personal and demographic contributors to relapse. Unfortunately, research has not documented treatments for SUDs – whether psychosocial or pharmacological in nature that adequately address the problem of relapse, however, new treatment models and modalities are being developed and implemented.

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